Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3420HOS	A. BUILDING _____ B. WING _____	06/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY HOSPITAL	5400 SOUTH RAINBOW BLVD LAS VEGAS, NV 89118

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S 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 06/16/09 and finalized on 06/17/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00021428 was substantiated with deficiencies cited. (See Tag # S0300) Complaint #NV00018877 was substantiated with no deficiencies cited. Complaint #NV00009991 was substantiated with no deficiencies cited. Complaint #NV00021300 was unsubstantiated. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000		
S 300	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the	S 300		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 300	Continued From page 1 disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure a patient received appropriate assessment and implementation of fall precautions to prevent additional falls and decubitus care assessment and treatment to prevent further exacerbation of a decubitus ulcer. (Patient # 3) Findings include: 1. A facility Incident Report dated 12/18/08 at 4:15 PM, indicated the patient was found on the floor of his room by a staff member from physical therapy. A Certified Nursing Assistant (CNA) and Registered Nurse (RN) responded to the patients room to assist with the patient's care. The patient's forehead was bleeding with a laceration. Pressure was applied to stop the bleeding and the patient was assisted back to bed. A manager passed by the patients room earlier and saw the patient sitting at the side of the bed using a urinal. The manager offered to assist the patient, who declined. The patient had been using a urinal at the bedside for 2 weeks. The patient's oxygen cannula was on and his call light was next to him. The patient's room was clear of debris and he appeared to be in a safe position. The patient appeared alert and orientated and responded appropriately. The physician was notified and ordered the patient transferred to the emergency room. The incident report documented fall precautions were in place at the time of the patients fall.	S 300		

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S 300	Continued From page 2 A facility Incident Report dated 01/04/09 at 11:20 PM, indicated the patient was found on the floor on his side by a CNA. The patient sustained a minor skin tear on the right elbow and a scratch on the right knee with dressings applied. The patient had just been cleaned earlier and was given a pain pill at 10:00 PM thru the PEG (percutaneous endoscopic gastrostomy) tube. The physician was called three times before staff finally got a hold of him at 12:15 AM and was informed of the incident. The patient was transferred to a medical floor. The patient's mentation at the time he fell was described as having periods of confusion. The patient had been reminded to use the call light several times and had been visited every now and then. Per the Charge Nurse the patient had 4 side rails up and a bed alarm on at the time of the fall. A CNA had cleaned the patient up 30 minutes prior to the fall and left the call light in reach. The facility's Fall Risk Assessment and Prevention House Wide Policy last reviewed 08/15/06 indicated under Purpose: 1. To identify patients at high risk for falls and prevent/reduce the possibility of injury from a fall. 2. Fall prevention interventions will be implemented according to risk level as defined in the procedure section. 3. Fall risk assessment will be completed on admission and every 12 hours, with change in condition, such as immediate post op patients, transfers to another department or in the event of a fall. The assessment will include the fall scale defined below and review of medications. 1. History of falling, immediate or within past 3	S 300		

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S 300	Continued From page 3 months. 2. Secondary diagnosis 3. Ambulatory aid, bed rest/nurse assist 4. IV (intravenous) or Heparin lock 5. Gait/Transferring: normal/bed rest/immobile, weak, impaired. 6. Mental status: orientated to own ability, unconscious, forgets limitations. 7. Medications: opiates, narcotics, sedatives, vasodilators, anesthesia, benzodiazepines, anticoagulants. Implementation of high risk fall prevention interventions included: 1. Staff member must remain with the patient when assisted to the bathroom. 2. Staff member must remain with the patient in a diagnostic or treatment area. 3. Communicate the patient's high risk status during shift report and with other disciplines as appropriate. 4. Inform and engage participation of patients family members regarding plan of care to prevent falls. 5. Re-orient patient, if patient is disorientated or confused. 6. Hourly checks or more frequently of patient by staff member. 7. Assess the need for 1:1 monitoring and arrange as needed. A Nursing Admission Assessment record dated 11/11/08, indicated the patient had a fall risk score of 50. (25 to 50 low risk) A Nursing Admission Assessment dated 11/20/08, indicated the patient had a fall risk score of 55. (> 55 high risk)	S 300		

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S 300	Continued From page 4 Nursing Note dated 12/18/08 at 5:00 PM, indicated the patient was found on the floor of his room calling for help. The patients forehead was bleeding. The physician was notified and ordered patient transferred to the emergency room for suturing of the patient's forehead. Nursing Note dated 01/04/09 at 10:00 PM, indicated the patient was medicated with Percocet 1 tablet via PEG tube. Nursing Note dated 01/04/09 at 10:20 PM, indicated the patient was seen by a CNA on rounds laying on the floor. The patient sustained a skin tear to his elbow and a small scratch to his right knee. The patient indicated he tried getting out of bed and skidded. Nursing Daily Assessment record dated 01/04/09, indicated the patient was alert but with bouts of confusion and general body weakness. A Physicians Order dated 01/05/09 at 12:15 AM, included, "Notify wife of fall incident...Place patient in Villi Bed (closed bed for safety) if available." On 06/17/09 at 11:10 AM, the Director of Risk Management indicated the facility did not have or use Villi beds. 2. A facility Emergency Nursing record dated 11/11/08 at 8:39 PM, indicated the patient was seen and evaluated in the emergency room for shortness of breath and decreased mentation. The patient was diagnosed with pneumonia and dehydration. Nursing Assessment record dated 11/11/08, indicated the patient had a stage 2 coccyx ulcer.	S 300		

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S 300	Continued From page 5 The Pressure Ulcer Assessment record was blank with no site, size, color, exudate, odor or drainage documented on the form. A Nursing Admission Assessment dated 11/12/08, documented the patient had a stage 2 to 3 ulcer on the right peri anal area. A Medical Surgical Shift Assessment form dated 11/12/08, indicated the patient had a stage 2 to stage 3 wound to the upper right buttock area. The color was pink/red, exudate/slight, peri wound skin/hyperpigmented with erythema. A Rehabilitation Unit Daily Nursing Documentation dated 11/22/08, indicated under integument that the patient had a stage 3 decubitus ulcer with DuoDerm. A review of physician orders from 11/11/08 to 12/04/08, revealed no documentation of orders for wound care or consultation by wound care. A Physicians Order dated 12/04/08, indicated an order for a wound consult secondary to a coccyx wound. A Physicians Order dated 12/12/08, indicated an order for wound care team to evaluate gluteal sores. A Physicians Surgery Consultation for evaluation of a Sacral Wound dated 02/06/09, indicated the patient was in rehabilitation at the facility and had a history of a spine fracture and had an open reduction internal fixation and had been in an Aspen collar. The patient developed a sacral decubitus ulcer. The assessment included a stage 3 sacral decubitus ulcer with necrotic tissue. The recommendation included Accuzyme,	S 300		

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S 300	Continued From page 6 debridement, soft air mattress, multivitamin, vitamin C and zinc. Wound Care Prevention, Staging and Treatment of Pressure Ulcer Policy dated 04/16/08 included the following: Policy: "All patients will be assessed for pressure ulcer risk using the Braden scale. This assessment will create a baseline for further skin and/or wound care, and minimize and/or prevent any further deterioration of tissue." Assessment and Documentation: "A score of 19 utilizing the Braden scale indicates risk of developing a pressure ulcer. Continue to assess daily." 1. "If there is a pressure ulcer present, it must be staged and wound care treatment initiated. Staging is documented using hospital guidelines (B-1)." 2. "Skin assessment and Braden scale documentation on admission and every shift." 3. "Prevention techniques employed." 4. "Support surfaces/devices utilized." 5. "Turning and positioning schedule." 6. "Wound care performed and products utilized." Treatment of pressure ulcers: 1. "It is the responsibility of the nurse caring for the patient to initiate the treatment for the pressure ulcer." 2. "If the condition of the skin deteriorates and/or the pressure ulcer is not healing, a specialty bed may need to be used. A physicians order for the specialty bed should be obtained." 3. "If consultation for treatment of a stage 3 or 4 pressure ulcer is needed, the Wound Care RN	S 300		

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S 300	Continued From page 7 consult may be called." Stage 2 : Cleanse with normal saline or wound cleanser. Apply transparent dressing or hydrocolloid wafer every 3 days. Stage 3: Cleanse with normal saline or wound cleanser. Apply wound hydrating gel to wound bed and apply non-adhesive dressing. Secure dressing with tape. Change dressing daily or as needed. On 06/17/09 at 9:50 AM, Employee #6 indicated if a patient was admitted with a stage 2 or 3 decubitus ulcer it would be the admitting nurses responsibility to notify the wound care nurse to conduct an evaluation of the patient within 24 hours for treatment. Severity: 3 Scope: 1 Complaint #NV00021428	S 300		